



# ELECTION WORKSHEET

## HOW MUCH SHOULD I CONTRIBUTE?

Use this worksheet to help estimate your annual FSA or HSA election:\*\*

MEDICAL EXPENSES NOT COVERED BY INSURANCE	Current Year's OOP* Expenses (\$)	Next Year's Estimated OOP* Expenses (\$)
Annual Physical/Routine Exam:		
Copays/Coinsurance:		
Deductibles:		
Diabetic Supplies:		
Immunizations (flu shots, etc.):		
Laboratory Fees:		
Maternity Expenses:		
Over-the-Counter Drugs:		
Prescription Drugs:		
Psychiatric/Psychologist Fees:		
Other:		
<b>Dental Expenses Not Covered by Insurance</b>		
Check Ups/Cleanings:		
Copays/Coinsurance:		
Crowns/Bridges/Dentures:		
Deductibles:		
Fillings:		
Oral Surgery:		
Orthodontia (braces):		
Root Canals:		
Other:		
<b>Vision Expenses Not Covered by Insurance</b>		
Contact Lenses:		
Contact Cleaners/Solutions:		
Copays/Coinsurance:		
Corrective Eye Surgery:		
Deductibles:		
Eye Exams:		
Eyeglasses:		
Other:		
<b>Total Out-of-Pocket Expenses:</b>	<b>\$0</b>	<b>\$0</b>

When deciding how much to set aside for next year's medical expenses, think about the following:

- ▶ Does anyone in your family have any medical, dental or vision expenses that will not be covered by insurance?
- ▶ Does anyone in your family need prescription eyeglasses, contact lenses and contact solutions or cleaners?
- ▶ Is anyone in your family currently in orthodontics (braces) or do you expect anyone to begin treatment in the next year?
- ▶ Does anyone in your family have an ongoing illness that requires frequent doctor visits and/or medication?

*\*Out-Of-Pocket*

*\*\*Election amount may not exceed your plan's cap or the maximum contribution amount allowed by the IRS, whichever is less.*